DATE RECEIVED _____

COMPLAINT NUMBER _____

KENTUCKY BOARD OF CERTIFICATION OF ALCOHOL AND DRUG COUNSELORS
PO BOX 1360
FRANKFORT KY 40602
502-564-3296
EXT 226

COMPLAINT FORM

YOUR NAME _____

ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME TELEPHONE NUMBER WITH AREA CODE _____

WORK TELEPHONE NUMBER WITH AREA CODE _____

NAME OF KY ALCOHOL AND DRUG COUNSELOR YOUR COMPLAINT IS AGAINST

_____

ADDRESS _____

_____

CITY _____ STATE _____ZIP _____

HAVE YOU FILED THIS COMPLAINT WITH OTHER AGENCIES _____ NO _____YES
(IF YES LIST THE AGENCY(IES)

_____

_____

_____

BRIEF SUMMARY OF COMPLAINT

Please attach copies of any supporting documentation pertaining to the complaint. (A copy of your complaint will be sent to the counselor asking for a response. Your complaint and response will be presented to the Board at the next scheduled meeting.)

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BY SIGNING THIS COMPLAINT FORM, I HEREBY CERTIFY THAT THE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____

AUTHORIZATION FOR RELEASE OF INFORMATION

1. The undersigned hereby ❑ request
❑ authorize:

_____
Person/Agency

_____
Address

_____
Address

to release information from the medical (health) record of:

_____
Name

_____/_____/_____ _____/_____/_____
Birth Date **ID Number**

2. Information to be released to:

_____
Person/Agency

_____
Address

_____
Address

3. Type of information to be released:_____

_____

4. Purpose for release:_____

_____

5. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate in 60 days unless otherwise stated.

Date: _____/_____/_____, or Event: _____

Prohibition on redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosue is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ _____/_____/_____
Signature of Client/Resident/Patient **Date**

_____ _____
Signature of Client's/Resident's/Patient's Agent or Representative **Witness**

_____
Relationship

_____
Address

_____
Address

This form must be returned with original signatures.